## INPATIENT CALIFORNIA HEALTHNET

🕂 Health Net.

## MEDICARE AUTHORIZATION FORM

For Standard (Elective Admission) requests, complete this form and FAX to 1-844-501-5713. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.

For Expedited requests, please CALL 1-800-929-9224. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

For Concurrent requests, complete this form and FAX to 1-844-501-5713. (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits). Determination within 24 hours of receipt of all necessary information.

MEMBER INFORMATION   Data of Birth,*     Member ID*   Last Name, First     Requesting NPI*   Requesting TIN *     Requesting NPI*   Requesting TIN *     Requesting NPI*   Requesting TIN *     Servicing Provider Name   Phone     Servicing NPI*   Servicing TIN *     Servicing NPi*   Additional Proceedure Code     Additional Proceedure Code   Servicing TIN *     Servicing NPicescium Code   Additional Proceedure Code   Servicing TIN *     Servicing NPicescium Code   Additional Proceedure Code   Servicing TIN *     Servicing NPicescium Code   Additional Proceedure Code   Servicing TIN * <t< th=""><th>*Indicates Required Field</th><th>ł ł</th><th></th><th></th><th>ato of Pirth</th><th></th></t<>	*Indicates Required Field	ł ł			ato of Pirth		
Requesting NPI   Requesting TIN   Requesting Provider Contact Name     Requesting Provider Name   Phone   Fax     SERVICING PROVIDER / FACILITY INFORMATION Same as Requesting Provider Servicing NPI   Servicing Provider Contact Name     Servicing NPI   Same as Requesting Provider Servicing NPI   Servicing Provider Contact Name     Servicing Provider/Facility Name   Phone   Fax     AUTHORIZATION REQUEST   Phone   Fax     Primary Procedure Code   Additional Procedure Code   Start Date OR Admission Date   Diagnosis Code *     Additional Procedure Code   Additional Procedure Code   Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity   Additional Diagnosis Code     Additional Procedure Code   Additional Procedure Code   Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity   Additional Diagnosis Code     IMPATIENT SERVICE TYPE*   (Enter the Service type number in the boxes)   .     ''''''''''''''''''''''''''''''''''''	MEMBER INFORMATION		Date of Birth *				
Requesting NPI   Requesting TIN   Requesting Provider Contact Name     Requesting Provider Name   Phone   Fax     SERVICING PROVIDER / FACILITY INFORMATION same as Requesting Provider servicing NPI   Servicing Provider Contact Name     Servicing NPI   Same as Requesting Provider servicing Provider/Facility Name   Phone   Fax     AUTHORIZATION REQUEST Primary Procedure Code   Additional Procedure Code   Start Date OR Admission Date   Diagnosis Code *     (2017) ACCS   (Mediler)   (Mediler)   (Mediler)   (col-10)   ·     Additional Procedure Code   Additional Procedure Code   Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity   Additional Diagnosis Code *     (PTI/ADPCS)   (Mediler)   (Mediler)   (Mediler)   (col-10)   ·     INPATIENT SERVICE TYPE*   (Enter the Service type number in the boxes)   ·   ·   ·     '19 Co-Section Delivery '19 Const Care   402 Skilled Nursing facility '19 Arenab   200 Transplant '19 Original Delivery '19 Arenab   200 Transplant '19 Original Delivery '19 Arenab   Additional Delivery   ALREQUIRED FIELED IN SURCOMPLETE FORMS WILL BE REJECTED	Member ID *	Last		Name, First (MMDDYYYY)			
Requesting Provider Name   Phone   Fax*     SERVICING PROVIDER / FACILITY INFORMATION			_				
SERVICING PROVIDER / FACILITY INFORMATION Same as Requesting Provider Servicing NPI* Servicing TIN * Servicing Provider Contact Name Servicing Provider/Facility Name Pone Fax Servicing Provider/Facility Name Pone Fax CUTHORIZATION REQUEST Primary Procedure Code Additional Procedure Code Start Date OR Admission Date * Diagnosis Code * CUTHORIZATION REQUEST Meditional Procedure Code Additional Procedure Code Discharge Date (ff applicable) otherwise Additional Procedure Code Additional Procedure Code (Medifier) Additional Procedure Code Additional Procedure Code (Medifier) Type Code (Medifier) (CPTH-CPCS) (Medifier) (Medifier) (CD-D) Medifier) (CPTH-CPCS) (Medifier) (Medifier) (Medifier) (CD-D) Medifier) (CPTH-CPCS) (Medifier) (Medifier) (Medifier) (CD-D) Medifier) (CPTH-CPCS) (Medifier) (Medi	Requesting NPI *	Requesting TIN	*	Requesting Provider Contact Name			
Same as Requesting Provider   Servicing TIN * Servicing Provider Contact Name     Servicing Provider/Facility Name   Phone   Fax     CUTHORIZATION REQUEST   Primary Procedure Code   Additional Procedure Code   Start Date OR Admission Date *   Diagnosis Code *     (CPT/NEOCS)   (Modifier)   (CPT/NEOCS)   (Modifier)   (ModDPYYY)   (CD-0)     Additional Procedure Code   Additional Procedure Code   Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity   Additional Diagnosis Code *     (PT/NEOCS)   (Modifier)   (PM/HOCS)   (Modifier)   (ModDPYYY)   (CD-10)     INPATIENT SERVICE TYPE*   (Enter the Service type number in the boxes)   Additional Diagnosis   Additional Proceedire Service type number in the boxes)     779 C-Section Delivery   402 Skilled Nursing Facility   402 Skilled Nursing Facility   402 Skilled Nursing Facility     900 Transplant   200 Transplant   720 Vaginal Delivery   720 Vaginal Delivery   Vaginal Delivery     414 Premature/False Labor   720 Vaginal Delivery   720 Vaginal Delivery   Vaginal Delivery	Requesting Provider Name	Phor		ie Fax *			
Servicing NPI*   Servicing TIN *   Servicing Provider Contact Name     Servicing Provider/Facility Name   Phone   Fax     AUTHORIZATION REQUEST   Nadifien   Additional Procedure Code   Start Date OR Admission Date *   Diagnosis Code *     (CP/HCPCS)   (Madifier)   (CP/HCPCS)   (Madifier)   (Mddifier)   (CD-R0)     Additional Procedure Code   Additional Procedure Code   Modifier)   (MdDDYYY)   (CD-R0)     Additional Procedure Code   (CP/HCPCS)   (Modifier)   (MdDDYYY)   (CD-R0)     ImpArtIENT SERVICE TYPE*   (Enter the Service type number in the boxes)   (CD-R0)     779 C-Section Delivery   402 Skilled Nursing Facility   209 Transplant     121 Long Term Acute Care   209 Transplant   720 Vaginal Delivery     124 Premative/False Labor   720 Vaginal Delivery   720 Vaginal Delivery     124 Premative/False Labor   720 Vaginal Delivery   720 Vaginal Delivery     124 Premative/False Labor   720 Vaginal Delivery   720 Vaginal Delivery     124 Premative/False Labor   720 Vaginal Delivery   720 Vaginal Delivery	1						
AUTHORIZATION REQUEST     Primary Procedure Code   Additional Procedure Code   Start Date OR Admission Date *   Diagnosis Code *     (CPT/HCPCS)   (Modifier)   (MMDDYYY)   (CD-10)     Additional Procedure Code   Additional Procedure Code   Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity   Additional Diagnosis Code     (CPT/HCPCS)   (Modifier)   (MMDDYYY)   (CD-10)     IMPATIENT SERVICE TYPE*   (Enter the Service type number in the boxes)   (CD-10)     779 C-Section Delivery 121 Long Term Acute Care 970 Medical 414 Premature/False Labor 427 Rehab   402 Skilled Nursing Facility 411 Surgical 920 Vaginal Delivery 427 Rehab				Servicing Provider Contact Name			
Primary Procedure Cole   Additional Procedure Cole   Start Date OR Admission Date *   Diagnosis Code *     (CPT/HCPCS)   (Modifier)   (CPT/HCPCS)   (Modifier)   (MMDDYYYY)   (CD-10)     Additional Procedure Code   Additional Procedure Code   Diagnosis Code   Additional Diagnosis Code     (CPT/HCPCS)   (Modifier)   (CPT/HCPCS)   (Modifier)   (MMDDYYYY)   (CD-10)     (TPT/HCPCS)   (Modifier)   (CPT/HCPCS)   (Modifier)   (MMDDYYYY)   (CD-10)     TYP C-Section Delivery   (CPT/HCPCS)   402 Skilled Nursing Facility   11 Surgical   209 Transplant     1414 Premature/False Labor   209 Transplant   209 Transplant   209 Transplant   209 Transplant     427 Rehab   XL REQUIRED FIELED KUST BE FILLED IN AS INCOMPLETE FORMS W	Servicing Provider/Facility Name	Phone		Fax			
(CPT/HCPCS)   (Modifier)   (Modifier)   (MMDDYYY)   (CD-10)     Additional Procedure Code   Additional Procedure Code   Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity   Additional Diagnosis Code     (CPT/HCPCS)   (Modifier)   (CPT/HCPCS)   (Modifier)   (MMDDYYY)   (CD-10)     INPATIENT SERVICE TYPE*   (Enter the Service type number in the boxes)   (CD-10)     779 C-Section Delivery 121 Long Term Acute Care 970 Medical 144 Premature/False Labor   402 Skilled Nursing Facility 209 Transplant 720 Vaginal Delivery 417 Surgical 209 Transplant   ++++++++++++++++++++++++++++++++++++	AUTHORIZATION REQUES	т					
Additional Procedure Code   Additional Procedure Code   Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity   Additional Diagnosis Code     (CPT/HCPCS)   (Modifier)   (CPT/HCPCS)   (Modifier)   (MMDDVYYY)   (ICD-10)     INPATIENT SERVICE TYPE*   (Enter the Service type number in the boxes)   (ICD-10)	Primary Procedure Code	Additional Procedure Co	ode	Start Date OR Admission Da	ite *	Diagnosis Code *	
Additional Procedure Code   Length of Stay will be based on Medical Necessity   Additional Diagnosis Code     (CPT/HCPCS)   (Modifier)   (MMDDYYYY)   (ICD-10)     INPATIENT SERVICE TYPE*   (Enter the Service type number in the boxes)   (ICD-10)     779 C-Section Delivery   402 Skilled Nursing Facility   121 Long Term Acute Care   411 Surgical     970 Medical   209 Transplant   209 Transplant   414 Premature/False Labor   720 Vaginal Delivery     427 Rehab   ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.   ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.	(CPT/HCPCS) (Modifier)	(CPT/HCPCS)	(Modifier)	(MMDDYYYY)		(ICD-10)	
INPATIENT SERVICE TYPE   (Enter the Service type number in the boxes)     779 C-Section Delivery   402 Skilled Nursing Facility     121 Long Term Acute Care   411 Surgical     970 Medical   209 Transplant     414 Premature/False Labor   720 Vaginal Delivery     427 Rehab   ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.	Additional Procedure Code Additional Procedure Code		ode	e Discharge Date (if applicable) otherwise E Length of Stay will be based on Medical Necessity		Additional Diagnosis Code	
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121 Long Term Acute Care   411 Surgical     970 Medical   209 Transplant     414 Premature/False Labor   720 Vaginal Delivery     427 Rehab   427 Rehab	INPATIENT SERVICE TYPE* (Enter the Service type number in the boxes)						
	121 Long Term Acute Care411 Surgical970 Medical209 Transplant414 Premature/False Labor720 Vaginal Delivery						
Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior		TING CLINICAL INFORMATION A	RE REQUIRED.	LACK OF CLINICAL INFORMATIO	ON MAY RESULT IN DEL		

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